| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155248 | A. BUILDING 01<br>B. WING | 08/02/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOLDEN LIVING CENTER-BRENTWOOD | 30 EAST CHANDLER AVE<br>EVANSVILLE, IN47713 |

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| K0000 | A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).<br><br>Survey Date: 08/02/11<br><br>Facility Number: 000152<br>Provider Number: 155248<br>AIM Number: 100267510<br><br>Surveyor: Lex Brashear, Life Safety Code Specialist<br><br>At this Life Safety Code survey, Golden Living Center - Brentwood was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.<br><br>This one story facility was determined to be of Type V (000) construction and was fully | K0000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| | sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The facility has a capacity of 114 and had a census of 76 at the time of this survey.<br><br>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/03/11.<br><br>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following: | | | |
| K0029 SS=E | One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1<br><br>Based on observation and interview, the facility failed to ensure 2 of 16 hazardous area room doors such as kitchen doors were equipped with self closing | K0029 | **K029** No residents have been affected. All doors within the facility will be inspected to assure they comply with LSC 19.3.2.1. The 2 doors identified during the tour will be corrected with the | 09/01/2011 |

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| | devices on the doors. This deficient practice could affect any of the 76 residents as well as staff and visitors during time spent in the Dining Room.<br><br>Findings include:<br><br>Based on observation on 08/02/11 at 12:45 p.m. during a tour of the facility with the temporary Maintenance Supervisor, the two kitchen doors were not provided with self closing devices. This was acknowledged by the temporary Maintenance Supervisor at the time of observation.<br><br>3.1-19(b) | | installation of proper self closing devices. All doors within the facility will be inspected once monthly during preventative maintenance rounds. If during daily use a door does not operate correctly, a work order will be submitted by staff and these will be monitored daily by Maintenance Director or designee. | |
| K0050 SS=F | Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2<br>Based on record review and interview, the facility failed to provide quarterly fire drill | K0050 | **K050**<br><br>No residents have been affected. | 09/01/2011 |

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| | documentation for 1 of 3 shifts during 2 of 4 quarters. This deficient practice could affect all residents in the facility.<br><br>Findings include:<br><br>Based on review of the facility's fire drills in the Life Safety Code Documentation Binder on 08/02/11 at 9:30 a.m. with the Administrator and the temporary Maintenance Supervisor present, the facility conducted twelve fire drills since July of 2010, however, they lacked written documentation fire drills were conducted during the second (evening) shift of the first quarter (January, February, and March), and second quarter (April, May, and June) of 2011. This was acknowledged by the Administrator and the temporary Maintenance Supervisor at the time of record review.<br><br>3.1-19(b) | | Documentation of all fire drills performed quarterly on each shift will be done and copies kept in the Life Safety Code Documentation Binder.<br><br>Copies of each drill will be reviewed by the Executive Director to assure compliance. A record of each drill will be entered into the Building Engines program. If not recorded timely, the District Maintenance Director will follow up with Maintenance Director or designee. | |

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| K0051 SS=F | A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station.<br>19.3.4, 9.6<br>Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm control panels located in an area not continuously occupied was provided with automatic smoke detection to ensure notification of a fire at that location before it is incapacitated by fire. NFPA 72 at 1-5.6 requires an automatic smoke detector be provided at the location of each fire alarm control unit which is not located in an area continuously occupied to provide notification of a fire in that location.<br>This deficient practice could affect | K0051 | **K051**<br><br>No residents have been affected.<br><br>Local fire alarm contractor contacted for installation of proper smoke detector by 9/1/11 to meet NFPA 72 at 1-5.6 requirements.<br><br>Maintenance Director or designee will monitor during monthly fire drills. | 09/01/2011 |

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| | all residents, staff, and visitors in the facility.<br><br>Findings include:<br><br>Based on observation on 08/02/11 at 12:20 p.m. during a tour of the facility with the temporary Maintenance Supervisor, the fire alarm control panel was located in the Mechanical Room near the Dining Room which was not electrically supervised by a smoke detector. This was acknowledged by the temporary Maintenance Supervisor at the time of observation.<br><br>3.1-19(b) | | | |